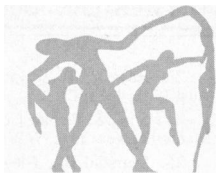


Women and Medicine

Chemical Dependency in Women
Meeting the Challenges of Accurate Diagnosis and Effective Treatment

KATHLEEN BELL UNGER, MD, *San Francisco*

Women dependent on alcohol or prescribed or nonprescribed psychoactive drugs present special diagnostic challenges to physicians. Chemical dependency likewise has adverse effects on women who are nonusers through the disease of co-dependency. The natural history of chemical dependency in women includes sex-specific differences in presenting signs and symptoms. Collateral medical history may come from a variety of community sources. Diagnoses may also use sex-specific criteria, with simultaneous diagnoses of chemical dependency and co-dependency considered.

(Unger KB: Chemical dependency in women—Meeting the challenges of accurate diagnosis and effective treatment, *In* Women and Medicine [Special Issue]. West J Med 1988 Dec; 149:746-750)

Women impaired by chemical dependency have historically escaped public attention. Before the early 1960s and the emergence of the current women's movement, female chemical dependency was regarded as a rare manifestation of an essentially "male" disease. Thus, it was often ignored, underreported, underdiagnosed, and most certainly undertreated. Over the past 25 years, old assumptions about women have been challenged. Society has gradually come to accept two important, superficially paradoxic ideas:

- Women are different; they are not smaller-body-mass versions of men.
- Women are the same; entry on an equal basis to many formerly "male provinces" is now expected.

After studying these social phenomena of the past quarter century, scientists now indicate[1,2] that the permanent alterations in the societal roles of American women have consequences that directly affect the patterns of female alcohol and psychoactive drug use. Traditional upbringing, with the mother not employed outside the home, continues to diminish. "Housewife" mothers were long thought to "shield" youngsters from drug exposure, and an increasing number of employed mothers imply less supervised sons and daughters who then become more available as candidates for drug use. In addition, today's assertive young women are not only likely to be more frequent participants in all risk-taking behavior, including drug experimentation, but they meet diminished societal disapproval for these behaviors.

We know far less about the course of chemical dependency in women than we do in men. We know less about its antecedents, its consequences, and how it is best treated. Practically no outcome studies have been done that compare the effectiveness of different types of treatment approaches for chemically dependent women. Current knowledge is summarized here, with an emphasis on identifying and meeting those sex-specific treatment needs of women patients that can be readily incorporated by their physicians into current treatment planning.

Chemical dependency is defined as the compulsive use of one or more psychoactive substances—drugs or alcohol or both—with resulting impairment of physical health, emotional health, social functioning, occupational functioning, or intimate relationships. It is a physical disease in that it involves tolerance, withdrawal phenomena, and increasing deleterious effects on numerous organ systems. It is a mental disease because the substance(s) is ingested specifically to alter brain function and, thus, life experiences. This diminishes the capacity for self-observation and for personal growth. It is a spiritual disease in that a chemically altered person is unable to fully participate in relationships with other persons, with his or her own life in general, with our planet as a whole, and with the past, present, and future. It is a family disease because other persons who may not use psychoactive chemicals find it impossible to live in the same household with an active chemical abuser and still maintain an objective perspective. Inevitably, their sense of self-worth comes to depend on the chemically dependent person's behavior. This fourth, or family, aspect of the disease can occur in persons who use no psychoactive substances whatever. This family aspect of chemical dependency is becoming recognized as another disease in its own right—that of co-dependency.

Chemically Dependent Women

Pathophysiology

Chemical dependency is not a moral weakness. In both men and women, it is not only a disease but also an illness. Whereas a disease is a disturbance in structure or function at a molecular, cellular, or organ system level,[3] an illness consists of both a disease and a person's experience of the disease. Diseases can be explained by molecular, anatomic, or physiologic derangements alone, but an illness can occur

From the Department of Psychiatry, University of California, San Francisco, Medical Center.
Reprint requests to Kathleen Bell Unger, MD, 2000 Van Ness Ave, Suite 710, San Francisco, CA 94109.

either with or without demonstrable disturbances at these levels. Illnesses always have at least some of their pathology at higher cortical, intrapsychic, interpersonal, or social levels. This involvement of the higher cortex can result in an illness picture in which symptoms are out of proportion to what might be expected from objective evidence of molecular, anatomic, or physiologic derangements. It may also result in an illness that fails to respond symptomatically to appropriate treatment.

Though prevalent to some degree in all aspects of clinical care, this interweaving of physiologic derangement, intrapsychic phenomena, and societal expectations is highly characteristic of women patients who present themselves to physicians for the treatment of chemical dependency.

Both chemical dependency and co-dependency may be diagnosed in the same patient. The first three aspects—the physical, emotional or psychological, and spiritual—apply to chemically dependent persons. The co-dependent, or family aspect, may accompany this diagnosis but be hidden by more flagrant symptoms of drug or alcohol abuse. Often co-dependency is the sole diagnosis, disguised as various physical symptoms.

Co-Dependency

Co-dependency has been called a disease of relationships in which the self-esteem of one person is regulated by the distorted behavior of another. A co-dependent person is now thought to be one who has a series of characteristics that lead that person to select a life partner who is chemically dependent or otherwise dysfunctional. Co-dependent women do not believe that they are capable of being loved; they settle for being needed. They are attracted to needy partners in whom they see potential. They believe that they can fix what is wrong with them and be loved in gratitude for this. This prospect is not only a thrilling possibility but also permits the reenactment of the situation of their family of origin—but with a chance to make the ending come out differently. They believe that if they work hard enough and long enough that this time they will be loved in return. Co-dependent women are exquisitely aware of the needs of others and, being preoccupied with the needs of their partner, they are protected from an awareness of their own pain and needs.

Co-dependent family members are greater-than-average users of medical care. They are particularly likely to suffer from the stress-related medical disorders.

Psychological Features of Chemical Dependency

Chemically dependent women differ from men as a whole, from chemically dependent men, and from women who are not chemically dependent in the following ways:

- They show "learned helplessness" in that they lack hope about their lives and feel guilty and responsible for their circumstances.
- They believe that they are "worse" than chemically dependent men, and the men they know agree with this.
- They have a more traditional and rigid view of appropriate female behavior and are acutely aware of their failure to live up to it.
- They find the transition into treatment so enormously disruptive that it is often the cause of treatment dropout.
- They have less education, make less money, are less likely to have health insurance, and have fewer life options. Thus, they are more likely to stay in dangerous, demeaning, and drug- or alcohol-abusing situations.
- They are more likely to have come from disturbed families marked by drug or alcohol dependency, mental illness, suicide, family violence, and personal physical or sexual abuse.
- They are less involved in criminal activity and are less likely to have drunk-driving arrests. They are, therefore, less often assigned to treatment diversion programs as a result of criminal activity.
- They are much more likely to have a husband or other life partner who is a drug or alcohol abuser or both.[4]

Clinical Course

What little we know about the sex-specific aspects of drug dependency and metabolism comes largely from studies on alcoholism. Women apparently begin misusing alcohol at a significantly later age than men but become dependent at the same life stage, while drinking less.[5] Dietary factors, with high saturated fats and low polyunsaturated ones providing some "protection" from cirrhosis,[6] are documented in men, but the possibly protective effect of female hormones is not. In some early literature, women appeared to achieve a higher blood alcohol concentration per unit of ingestion than did men, but this did not hold true when corrected for the sexes' differing total body water content. An apparent "telescoping," or more rapid downhill course of alcoholism, is clearly evident: women start drinking alcohol at a later age, catch up fast, and get just as sick as the men do at about the same time of life or earlier.

Current literature suggests that alcohol dependency disrupts the lives of women more profoundly than it does those of men, suggesting that other drugs of abuse tend to do the same.

Women need not even be particularly aggressive in seeking an addiction career, for it may seek out them. According to O'Donnell and colleagues,[7] drug dependency is more likely to be established in the husband and then transferred to the wife, rather than vice versa. Addicted women are far more likely than addicted men to be married to, or romantically attached to, other addicts.[8] Although addicting chemicals have long been seen as sexualized—most street drugs have undeserved reputations as aphrodisiacs—changing fashions periodically demonstrate a unique form, and a new wrinkle in the courtship process has been documented[9]: Surveyed callers to an 800-COCAINE hotline indicated that cocaine has become accepted as a courtship ritual gift, just as were the more traditional candy and flowers. Of surveyed women callers, 87% had been introduced to cocaine use by men.

Primary Prevention

Kandel and Yamaguchi,[10] observing the initiation of both prescribed and illicit drug use in adolescents and its longitudinal history, followed a population of 15-year-old New York State high school study subjects for ten years. Their findings indicated that almost 20% of the students of both sexes had used alcohol by age 10 and more than 50% by age 14. A similar initiation-of-use rate was shown for cigarettes. Marijuana use was initiated at about age 13. Rates for initiating the use of all three of these drugs climbed until age 18, when a sharp dropoff occurred, followed by a pattern of stabiliza-

tion of the amount of use in those who continued to use the substance(s).

Important for all physicians is the finding that the initiation of prescribed psychoactives use occurred largely in the female population, beginning at a later age—around 18.[10] This is the very same period at which the initiation of illicit drug use started to decline. The rate of prescribed psychoactive drug use continued to rise in women after age 18. Psychoactive drugs were in current use by 13% of women studied at age 23.

In turn, this prescribed drug use was found to occur most readily in women who already had a past or present use of illicit drugs in their personal history. These young women not only showed depressive symptoms but gave familial histories of a maternal use of psychoactive drugs.[10] The researchers concluded that the prescribing of "minor" tranquilizers by physicians appeared to be an important factor in the course of addiction in women and thus a potential locus for preventing drug abuse.

Diagnosing Chemical Dependency

Chief Complaints

Chemically dependent women differ from other women patients in the following ways:

- They are not likely to recognize that drug or alcohol use is a source of problems in itself. They see such use as a way of coping with losses, with family problems, with a bad or violent relationship with a partner, and with medical illness, child-related stresses, or poverty.
- They fail to see how drug or alcohol use makes problems substantially worse.
- They see their drug or alcohol use as part of a solution, or as an attempt to cope with whatever is the "real" problem.
- They are more likely to seek help for problems other than drug or alcohol use. They do this first through social service agencies, not physicians. Seeking some form of help for children is a common presentation.
- They are more likely than men to have difficulties with drugs that are more socially acceptable—alcohol, for example. For this reason, their difficulties are often initially not seen as problematic because their drug is one used moderately and appropriately by most persons.
- The social stigma attached to admitting drug or alcohol problems encourages them to mislabel their problems.[11]

Medical History Taking

A physician can easily improve the taking of an adequate history in this area by incorporating one or more of the MAST, CAGE, or FOY tests in the initial evaluation of every nonpediatric patient (Figures 1, 2, and 3).[12-14] These simple, self-administered tests can be included in the medical history forms filled out by a patient.

Chemically dependent women experience more medical complications of chemical dependency than men do. They are more likely to present to their physicians with physical complaints. Most common are constitutional symptoms: headache, dizziness, abdominal or extremity pain, and requests for checkups on vague indications. Along with their physicians, they are unlikely to recognize the role that chemical dependency plays in their presenting symptoms and, like most women, they believe in the efficacy of medical treatment—more so than do men.[11]

Differential Diagnosis

A clue for physicians considering the differential diagnosis of chemical dependency is found in a clinical course in which symptoms do not improve, in spite of adequate diagnostic workup, prescribed treatment, and patient education. This may occur in a patient diagnosed as having either chemical dependency or co-dependency. At such times, a simultaneous diagnosis of co-dependency must be reconsidered. By the persistence of her dysphoric symptoms, a patient may be indicating that a second diagnosis has been missed.

Improving the Rate of Diagnosis

A "diagnosis" of chemical dependency is often first made by members of a woman's community, often long before she reaches the attention of any medical care giver.[11] They may include divorce attorneys, social workers from child protective services, the staff of battered women's shelters, or hospital emergency department personnel. Other knowledgeable people may be their children's teachers (through parents' nights, the Parent-Teachers' Association, or required school volunteer service by parents), the staff of preschools, day-care center staff, and others in the community, such as neighborhood beauticians, neighborhood pharmacists, aerobics instructors, weight-reduction salon staff, community college and continuing education teachers (especially for child development, psychology, and law-for-the-layperson classes), and local Al Anon, Nar Anon, and Overeaters Anonymous groups. These people are stunningly accurate in their diagnoses, but do not know what to do with their information. Physicians are wise to give serious consideration to any incidental, perhaps unexpected, contributions to the comprehensive medical history of a patient provided by such sources.

Physicians can also improve their rates of diagnosis if they raise their level of suspicion for patients giving medical histories that place them in one of the high-risk groups for substance abuse: incest survivors, members of genetically vulnerable families, women with chronic pain, spouses of practicing alcoholics, and battered women.[11] Physicians must be aware of the common intercurrent physical disorders by which many women express their underlying chemical dependency: eating disorders and agoraphobia. The accuracy of diagnoses may also be improved by physicians letting

CAGE Test

- Have you ever felt you should *C*ut down on your drinking?
- Have people ever *A*nnoyed you by criticizing your drinking?
- Have you ever felt bad or *G*uilty about your drinking?
- Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (*E*ye opener)?

Figure 1.—The CAGE test: A "Yes" answer to 2 or more of the questions indicates a problem with alcohol use (from the American Psychiatric Association[13]).

FOY Test

- Do your *F*riends ever worry about your drinking?
- Do *O*thers ever worry about your drinking?
- Do *Y*ou ever worry about your drinking?

Figure 2.—The FOY test (from Talbott[14]).

their patients know that they are both knowledgeable and interested in problems of chemical dependency. This simple maneuver serves to encourage patients to inform their physicians about these health issues in their lives—and at an earlier stage of the disorder. This can be accomplished by the presence of outreach educational brochures in physicians' waiting rooms.

Selected periodicals in a physician's waiting rooms can signal the physician's interest in chemical dependency health problems. These can include the Alcoholics Anonymous magazine, *Grapevine,* and the publication, *Changes,* which is directed at adult children of dysfunctional families. A discreet sign stating a willingness to discuss chemical dependency problems may be in order.

Treatment of Chemically Dependent Women

As with all patients, medical treatment begins with establishing a good physician-patient relationship.[15] It is necessary to respect a patient's own beliefs about the physical or external causes of her distress and her chemically dependent behavior. Given her low self-esteem, too-early confrontation of her denial of drug or alcohol misuse may lead to more entrenched convictions and her dropping out of treatment. It is better for the physician to praise her for having done something about her problems—that is, by seeking help—without disputing the validity of her complaints. Once an atmosphere of trust is established, it is easier to convince a patient that her alcohol or drug use is not helping but is making things worse. She may then be motivated to accept treatment for this aspect of her problems that is readily under her control. In the light of a revealed alcohol or drug misuse pattern, assisting patients to relabel their presenting symptoms is appropriate.[16] Although most people experience minor pains or sensory disturbances in the course of each day, to chemically dependent patients, all such symptoms are "labeled" abnormal and something with which they cannot cope without their self-prescribed dose of psychoactive substance. Assisting them to relabel these discomforts as normal will render them bearable.

Not all physicians have the time and the medical practice setting requisite for confirming their diagnostic suspicions, nor for personally treating all of the chemically dependent patients they see. Such physicians serve their patients well by a prompt and timely referral to a definitive treatment resource. By doing so, they may well earn the profound gratitude of both patients and their families.

Information Resources for Practicing Physicians

- California Medical Association's Chemical Dependency Education Program for Physicians

This is a continuing medical education program on alcoholism and other drug dependencies, designed for hospital medical staffs. The program consists of four one-hour modules that address physicians' attitudes on chemical dependency, early diagnosis, confirming the diagnosis and initiating treatment, and physicians' role in recovery. This program is authorized for up to four hours of continuing medical education, category I, credit. For more information or to make arrangements for presentation of the program, contact Ms Fern Leger, California Medical Association, PO Box 7690, San Francisco, CA 94120-7690; (415) 541-0900, extension 417.

- "Health Tips on Substance Abuse"

Published by the California Medical Education and Research Foundation, these are prepared by physician members of the California Medical Association and are free to its

MAST Test

Do you feel you are an abnormal drinker?	Yes ☐	No ☐	(2)
Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening before?	Yes ☐	No ☐	(2)
Does your spouse (or parents) ever worry or complain about your drinking?	Yes ☐	No ☐	(1)
If you stop drinking after one or two drinks, is there a struggle? Do you really want more?	Yes ☐	No ☐	(2)
Do you ever feel bad about your drinking?	Yes ☐	No ☐	(1)
Do friends or relatives think you are an abnormal drinker?	Yes ☐	No ☐	(2)
Do you ever try to limit your drinking to certain times of the day or to certain places?	Yes ☐	No ☐	(0)
Are you unable to stop drinking when you want to?	Yes ☐	No ☐	(2)
Have you ever attended a meeting of Alcoholics Anonymous (AA)?	Yes ☐	No ☐	(5)
Have you gotten into fights when drinking?	Yes ☐	No ☐	(1)
Has drinking ever created problems with you and your spouse?	Yes ☐	No ☐	(2)
Has your spouse (or other family member) ever gone to anyone for help about your drinking?	Yes ☐	No ☐	(2)
Have you ever lost friends or girlfriends/boyfriends because of drinking?	Yes ☐	No ☐	(2)
Have you ever gotten into trouble at work because of drinking?	Yes ☐	No ☐	(2)
Have you ever lost a job because of drinking?	Yes ☐	No ☐	(2)
Have you ever neglected your obligations, your family or your work for 2 or more days in a row because you were drinking?	Yes ☐	No ☐	(2)
Do you ever drink before noon?	Yes ☐	No ☐	(1)
Have you ever been told you have liver trouble? cirrhosis?	Yes ☐	No ☐	(2)
Have you ever had delirium tremens ("DTs"), severe shaking, heard voices, or seen things that weren't there after heavy drinking?	Yes ☐	No ☐	(2)
Have you ever gone to anyone for help about your drinking?	Yes ☐	No ☐	(5)
Have you ever been in a hospital because of drinking?	Yes ☐	No ☐	(5)
Have you ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital where drinking was part of the problem?	Yes ☐	No ☐	(2)
Have you ever been seen at a psychiatric or mental health clinic or gone to a doctor, social worker, or member of the clergy for help with an emotional problem in which drinking had played a part?	Yes ☐	No ☐	(2)
Have you ever been arrested, even for a few hours, because of drunken behavior?	Yes ☐	No ☐	(2)
Have you ever been arrested for drunk driving or driving after drinking?	Yes ☐	No ☐	(2)

Figure 3.—The MAST test: Points are scored as indicated for all Yes answers. Any score above 4 is considered pathological drinking (from Talbott[14]).

members. Written in layperson's language, these sheets are formatted for easy reproduction and distribution in physicians' offices.

- National Clearinghouse for Alcohol and Drug Abuse Information, PO Box 2345, Rockville, MD 20852

A mailing list for the "Announcement of New Publications." Free, single copies of these will be sent on request. Publications include basic science, practical patient care techniques, patient education, and the like.

- 1987-1988 National Directory of Alcohol, Drug Abuse and Other Addictions Treatment Programs

Published by the US Journal of Drug and Alcohol Dependence, *3201 SW 15th Street, Deerfield Beach, FL 33442. They also publish a patient education magazine,* Changes.

- Drug Abuse and Alcoholism Newsletter

Published by the Vista Hill Foundation, 3420 Camino del Rio North, Suite 100, San Diego, CA 92108. A free four-page monthly publication, each issue focuses in detail on one aspect of chemical dependency. Topics range from the subcellular to major societal trends.

- About AA

Published by Alcoholics Anonymous, Box 459 Grand Central Station, New York, NY 10163. A free, one-page quarterly newsletter for medical professionals, it describes the various AA services and their attempts to meet the needs of special groups. They also publish Grapevine, *a monthly magazine for recovering alcoholics.*

REFERENCES

1. Bell CS, Battjes R: Prevention research: Deterring drug abuse among children and adolescents. Natl Inst Drug Abuse Res Monogr Ser 1985; 63:8-11

2. Ensminger ME, Brown CH, Kellam SG: Social control as an explanation of sex differences in substance use among adolescents. Natl Inst Drug Abuse Res Monogr Ser 1984; 49:296-304

3. Kaplan C, Lipkin M, Gordon GH: Somatization in primary care. J Gen Intern Med 1988; 3:177-190

4. Baumrind D: Familial antecedents of adolescent drug use: A developmental perspective. Natl Inst Drug Abuse Res Monogr Ser 1985; 56:13-44

5. Stabenau JR: Alcohol consumption: Effects of gender on psychopathology. Am J Psychiatry 1984; 6:1178-1182

6. Nanji AA, French SW: Dietary factors and alcoholic cirrhosis. Alcoholism (NY) 1986; 10:271-273

7. O'Donnell JA, Besteman KJ, Jones JP: Marital history of narcotic addicts. Int J Addict 1967; 2:21-38

8. Frakas MI: The addicted couple. Drug Forum 1976; 5:81-87

9. Washton AM: Special report: Women and cocaine. Med Aspects Human Sexual 1986; 20:128-132

10. Kandel DB, Yamaguchi K: Developmental patterns of the use of legal, illegal, and medically prescribed psychotropic drugs from adolescence to young adulthood. Natl Inst Drug Abuse Res Monogr Ser 1985; 56:193-235

11. Mondanaro JM: Chemically dependent women. Natl Inst Drug Abuse Res Monogr Ser, in press

12. Ewing JA: Detecting alcoholism: The CAGE questionnaire. JAMA 1984; 252:1905-1907

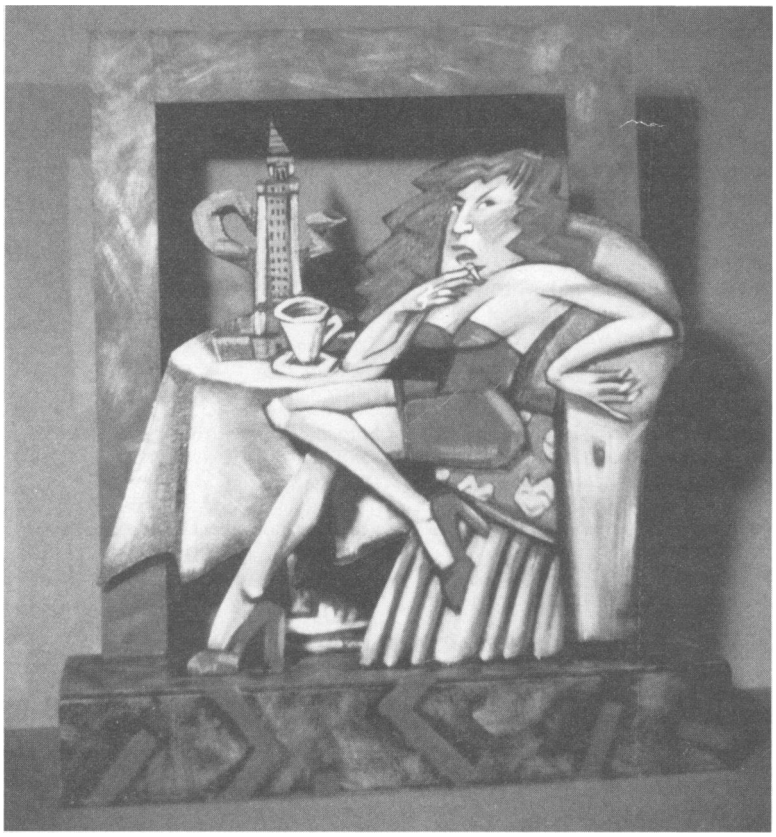
13. Mayfield DG, McLeod G, Hall P: The CAGE questionnaire: Validation of a new alcoholism screening instrument. Am J Psychiatry 1974; 131:1121-1123

14. Talbott GD: Alcoholism and other drug addictions: A primary disease entity. J Med Assoc Ga 1986; 75:490-494

15. Westermeyer J: Role of the family physician in the diagnosis and treatment of substance abuse. Semin Family Med 1980; 1:237-254

16. Daghestani AN: Identifying addictive disorders in office practice. Med Aspects Human Sexual 1987; 22:28-35

* * *



Blanche

Medium: Acrylic on Wood

With permission from Katrin Wiese, Box 1513, Riverside, CA 92502.